SUMMIT LEARNING CENTER
2017-2018
ANNUAL STUDENT HEALTH RECORD

Student Name (Last, First, Middle): _____ **Grade:** _____

Home phone: _____

Dad's work phone: _____ Dad's cell phone: _____

Mom's work phone: _____ Mom's cell phone: _____

Emergency Contact - adult relative/friend who can be reached if a parent/guardian is unavailable:

Name: _____ Phone: _____ Relationship to student: _____

Primary Health Care Provider: _____

Clinic and Phone: _____

Hospital Preference: _____

Health Insurance: ____ Medical Assistance ____ Minnesota Care ____ Private ____ None

Health Concerns: Please mark if your child has any of these health concerns.

____ **No Health Concerns**
____ Allergies (list) _____
Does your child have an Epi-pen? ____ Will he/she have one at school? ____
____ Asthma or other breathing problems
Does your child use an inhaler? ____ Will it be used at school? ____
____ Seizures
____ Diabetes
____ ADHD/ADD
____ Heart Problems (describe) _____
____ Social/emotional/mental health concerns (describe) _____
____ Activity restrictions (describe) _____
____ Recent surgeries or hospitalizations (describe) _____
____ Other health concerns (describe) _____

Medications: List **ALL** medications that your child takes every day or when needed. A consent form is required for all medications taken at school, including over the counter medications. Prescription medications require a separate consent signed by both health care provider and parent.

Medication Name	Purpose	Dose	Given at school?

Immunizations received within the last year:

1. _____ Date received _____
2. _____ Date received _____
3. _____ Date received _____

Parent/Guardian Signature _____ Date: _____

For your child's safety, this information may be shared with school personnel working with your child. If you have questions or concerns please contact School Nurse Deb Jergenson at 507-896-5323, extension 1133.